

FEDERAL BUREAU OF INVESTIGATION

National Office of Vital Statistics

FILED OCT 18 1948

Registration District No.

318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

1003

State File No.

34003

Registrar's No.

8691

1. PLACE OF DEATH:

- (a) County _____
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jewish Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME VERN D. CHINGREN3. (b) If veteran,
name war _____

3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Aina 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 20 1920
(Month) (Day) (Year)

8. AGE: Years 28 Months 3 Days 13 If less than one day
hr. _____ min. _____

9. Birthplace Boxholm Iowa
(City, town, or county) (State or foreign country)
10. Usual occupation Youth Director
11. Industry or business Y.M.C.A.
12. Name Reuben Chingren
13. Birthplace Boxholm Iowa
(City, town, or county) (State or foreign country)
14. Maiden name Viola Schult
15. Birthplace Boxholm Iowa
(City, town, or county) (State or foreign country)

MOTHER FATHER

16. (a) Informant Aina Chingren
(b) Address Route # I Pevely Mo.
17. (a) Removal (b) Date thereof Oct 6 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Boxholm Iowa
18. (a) Signature of funeral director Leeta Funeral Home
(b) Address 3029 Lafayette Ave St. Louis, Mo.
19. (a) OCT 6 1948 (b) J.B. Lasater
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Jefferson 50
(c) City or town Pevely Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. Route # I (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 3
year 1948 hour II minute 20 P.M.

21. I hereby certify that I attended the deceased from
Oct, 19 , to Oct 3, 1948;
that I last saw him alive on Oct 3, 1948;
and that death occurred on the date and hour stated above.

Immediate cause of death
Acute pulmonary Edema 5 hrs.
Due to Chronic glomerulonephritis 6 yrs.
Hypertensive Vascular Disease 6 yrs.
Due to _____

Other conditions Pulmonary Tuber- 3 yrs.
(Include pregnancy within 3 months of death)
culosis - Diabetes
Major findings:
Of operations _____

Of autopsy Pul. TBC - Far advanced
chronic glomerulonephritis
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
(c) Means of injury _____
23. Signature Moine Alex M. D. (M.D. or other)
Address Jewish Hospital Date signed 4 Oct. 48
St. Louis, Mo.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed David Lee Farrow

Licensed Embalmer No. 4242

P. O. Address 3029 Lafayette

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.